

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC Accepted  
on 10/2/09 by  
[Signature]

PRINTED: 09/15/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/21/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARSON NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2898 HIGHWAY 50 EAST CARSON CITY, NV 89701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on August 17, 2009 through August 21, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities.  The census was 53 residents. The sample size was 14 sampled residents which included 2 closed records, and 4 unsampled residents.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  The following regulatory deficiencies were identified:	F 000	This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.  <b>RECEIVED</b>  SEP 25 2009  BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on record review, interview, and document review, the facility failed to ensure 2 of 14 residents received social service interventions to attain their highest practicable psychosocial well-being (Residents #3, #9).  Findings include:	F 250	<b>Identifying Prefix Tag F - 250: SOCIAL SERVICE</b>  <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident #3 was moved to a new room on 8/20/09. She was able to preview the room and agreed to the room change. Resident # 3's daughter was informed of the room change and in agreement. On 8/21, 8/24, and 8/26, Social service checked with resident # 3 and she said she was happy in her new room. <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Residents will be given the option to preview open rooms if not satisfied with current room. Social worker and		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Administrator

(X6) DATE

9/25/09

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	<p>Continued From page 1</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on 1/8/09, with diagnoses including unilateral amputation below the knee, diabetes, vascular disease, and depression.</p> <p>The admission Minimum Data Set (MDS) dated 4/7/09, revealed the resident was able to make consistent and reasonable decisions, with some difficulty in decision-making in new situations only.</p> <p>Record review revealed a note written on 7/16/09 by the facility's social worker, Employee #7, which documented that Resident #3 "was upset this morning because her roommate accused her of stealing and her other roommate keeps her awake at night talking in her sleep." The note further revealed the resident's daughter was "very concerned about her mother's lack of motivation and sadness." Another note written by Employee #7 on 7/27/09, indicated the resident was still upset about her room situation. The social worker wrote, "I told her we would try to find her a different room."</p> <p>At the beginning of the survey on 8/17/09, Resident #3 was observed still residing in the same room, with the same roommates. When asked about her room situation, the resident related that one of her roommates kept her up at night. The resident further communicated she spoke with the social worker about wanting to move to a different room.</p> <p>The social worker was interviewed on 8/17/09 at 2:45 PM. When asked about the status of finding</p>	F 250	<p>Continued from page 1</p> <p>admissions will make every effort to accommodate a change if necessary. Once moved residents will be asked daily for 72 hours if they are satisfied with the change.</p> <p><i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Facility Administrator or designee will continue to monitor resident's adjustment to new room daily and weekly until lesser frequency is deemed appropriate.</p> <p><i>Facility plan to monitor corrective actions &amp; sustain compliance; integrate QA Process;</i> Concerns and trends with the outlined procedure will be addressed daily in facility morning meeting. Any trends identified will be reviewed by the facility Quality Assurance committee monthly and addressed immediately.</p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 9 is no longer in this facility</p> <p><i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Social service will continue to monitor all residents and new admissions using the Covenant Care Safety Surveillance Care Assessment protocol.</p> <p><i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Facility staff have been in-service to notify social service of unusual emotional or behavior patterns on 9/9/09 by director of nursing designee. See attachment #12</p> <p><i>Facility plan to monitor corrective actions &amp;</i></p>		

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F 250	<p>Continued From page 2</p> <p>a different room for Resident #3, the social worker stated, "I assumed everything was okay since she didn't say anything about it when I came in to say hi."</p> <p>On 8/19/09 at 8:35 AM, Resident #3's daughter was contacted by phone and confirmed her mother said she wanted to have a new room. The daughter also related that her mother did not always speak up about her concerns, adding, "If we don't ask her, she won't tell us."</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on 9/26/08 with diagnoses that included a right below the knee amputation, diabetes type II and anxiety.</p> <p>An entry by Employee # 7 (the social worker) documented that a note received by her (the social worker) declared Resident #9 said he wanted to kill himself. Employee #7 further noted she interviewed the resident who declared that he was frustrated, depressed and discouraged but was not going to kill himself. Employee #7 told the resident to contact her if he wanted to talk again. There was no documentation that any additional steps were undertaken.</p> <p>The social worker's progress notes over the next several days disclosed there was no additional discussion of Resident #9's psychological status. At the time of the incident, Resident #9 was experiencing additional stress factors due to some difficulties with the fit of his prosthetic leg and having received a thirty day notice for non payment of his financial responsibility of the facility's bill.</p>	F 250	<p>Continued from page 2</p> <p><i>sustain compliance; Integrate QA Process;</i> Facility administrator or designee will ensure compliance. Any concerns and trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p>		<p>Completion Date(s): 09/30/09</p>

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F 250	Continued From page 3  An interview with Employee #7 on 8/20/09 at 1:35 PM, revealed she was not sure from whom she received the note or did Employee #7 recall if she notified anyone in administration of the situation. Employee #7 disclosed that social services maintained a list of residents who should be seen by the psychiatrist during his weekly visits and that Resident #9 had been placed on the list for depression. Employee #7 did not feel the resident was a suicidal risk. Employee #7 was not sure what the facility's policy was for potential suicidal behavior.  Review of the facility policy entitled "Suicide Prevention Policy," dated November 2008, revealed the purpose, policy, criteria to be considered for Suicide Potential, the procedure and health record documentation. The policy also contained articles dealing with suicide. The policy was unclear as to what should be done from the time that staff thought there might be a potential suicide threat until suicide precautions were initiated by the attending physician, psychiatrist, psychologist, director of nursing or charge nurse with a doctor's order. The policy did not define who was able to determine if the resident was at risk for suicide.  There was no evidence that Employee #7 followed through with an evaluation or further assessment of Resident #9's psychological status.	F 250		
F 309 SS=E	483.25 QUALITY OF CARE  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	<b>Identifying Prefix Tag F- 309:</b> <b>QUALITY OF CARE</b> <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 8: wellbutrin was decreased from 150mg to 75 mg on 7/15/09 then	

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F 309	<p>Continued From page 4 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and document review, the facility failed to ensure that pharmacist recommendations approved by the medical director were implemented for 1 of 14 sampled residents (Resident #8), and 3 of 4 unsampled residents (Residents #16, #17, #18). The facility failed to provide pain medication in a timely manner to 1 of 4 residents (Resident #1), failed to ensure that the prescribed medication was available for 1 of 14 residents (Resident #4), and failed to clarify the physician's order when it was written, to ensure that the appropriate medication was available and failed to treat the resident's elevated blood sugar as ordered for 1 of 14 residents (Resident #9).</p> <p>Findings include:</p> <p>Resident #8</p> <p>Resident #8 was admitted to the facility on 12/29/08, with diagnoses including chronic obstructive pulmonary disease, coronary artery disease, anxiety, and hypertension.</p> <p>The Consultation Report revealed the facility's consultant pharmacist's recommendation on 5/19/09, to administer Paxil at night rather than during the day because of the drowsiness effect of the medication and to re-evaluate the concomitant use of two anti-depressant medications Paxil and Wellbutrin. The resident's</p>	F 309	<p>Continued from page 4</p> <p>discontinued on 7/30/09. Paxil continues to be given at night as ordered on 12/29/08. See attachment F-309, #1 Resident #16: Restoril was reduced to 15mg PRN on 7/31/09. See attachment F-309, #2 pg 5 Resident # 17: currently receiving 81 mg of aspirin daily since 7/13/09 per pharmacy consultant recommendation and physician order. See attachment F- 309, #3, pg 5 Resident # 18 Lipid profile was completed on 7/16/09 with no further treatment done per physicians response to pharmacy recommendation. See attachment F- 309, #4, pg 5 <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Facility developed a system to ensure prompt and efficient processing of pharmacy consultant reports by nursing. The process includes review of the pharmacy reports by the Director of nursing who provides copies to the physicians then delegate follow through to the nursing staff. <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Licensed nursing meeting was conducted by Director of Nursing on 9/9/09 regarding effective communication of this process. Director of nursing or Designee will ensure process is followed through and</p>	

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F 309	<p>Continued From page 5</p> <p>physician documented on 5/20/09, his approval of these recommendations by agreeing to change the administration time of Paxil and to notify the facility's consultant Doctor of Osteopathic Medicine (D.O.) regarding the two anti-depressants.</p> <p>Nursing received the approved Consultation Report two months later on 7/14/09 and notified the D.O. then. The D.O. then wrote an order on 7/14/09 to first decrease and then discontinue Wellbutrin. A review of the resident's July 2009 Medication Administration Record (MAR) revealed that starting on 7/14/09, Paxil was given at night rather than in the morning.</p> <p>Resident #16</p> <p>Resident #16 was admitted to the facility on 4/30/09, with diagnoses including lung cancer and anxiety.</p> <p>On 5/19/09, the facility's consultant pharmacist recommended on his Consultation Report to reduce the anti-hypnotic Restoril from 30 milligrams (mg) to 15 mg, because, as explained in the comment section of the report, "the recommended maximum daily dose threshold for this medication when used to treat insomnia is 15 mg." The resident's physician documented his approval of this medication reduction on 5/20/09.</p> <p>A review of Resident #16's record revealed a note written on 6/23/09 by a Licensed Practical Nurse (LPN) Employee #9, that the resident assumed the order for Restoril was updated to reflect a lower dose. "At 1:30 AM (the resident) requested Restoril, but when taking the medication, stated 'the 15 mg's are bright orange.' Informed her</p>	F 309	<p>Continued from page 5</p> <p>complete.</p> <p><i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 1 We will continue to monitor resident for pain and effectiveness of medications. See attachment F- 309, # 6 <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Licensed nurses were in-service on 9/9/09 of new procedure of physician notification (See attachment F- 309, #5, pg 5). Physicians are to be notified immediately by phone of acute change of condition. All non-acute physician notifications will be documented on physician log and the AM nurse will contact the Physician every two hours until a response is received. Monday through Friday each AM the director of nursing or designee will review the physician notification log to ensure all issues have a response from the physician.</p> <p><i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> The Medical Director will be notified of any issues in this process. Administrator, or Director of Nursing Designee will</p>	

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F 309	<p>Continued From page 6</p> <p>order was for 30 mg. She then wanted 'just 1/2.' I told her no way to open capsule to give 1/2, and 30 mg was what was ordered." A review of the resident's MAR revealed that the resident refused to take Restoril after 6/23/09 because "she only wants 1/2 of it."</p> <p>Nursing received the approved Consultation Report two months later on 7/14/09.</p> <p>Resident #17</p> <p>Resident #17 was admitted to the facility on 7/30/09, with diagnoses including diabetes, cardiomyopathy, diabetes, and depressive disorder.</p> <p>On 5/19/09, the facility's consultant pharmacist made a recommended on the Consultation Report to decrease the dose of aspirin, taken for "prevention of cardiovascular events" from 325 mg to 81 mg His rationale for the dose reduction was documented as "Higher doses (i.e. greater than 160 mg/day) have not demonstrated further risk reduction, but may increase risk for gastrointestinal and other bleeding events." On 5/20/09, the resident's physician documented on the Consultation Report his acceptance of this recommendation.</p> <p>Nursing received this approved Consultation Report two months later on 7/14/09, and the order, as indicated on the resident's July 2009 MAR, was changed to 81 mg on 7/14/09.</p> <p>Resident #18</p> <p>Resident #18 was admitted to the facility on 5/20/05, with diagnoses including dementia,</p>	F 309	<p>Continued from page 6</p> <p>ensure process is followed through and complete.</p> <p><i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 4 Facility will ensure pharmacy provides adequate stock of routine pain medication. See attachment #7.</p> <p><i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Refill orders of pain medication will be faxed to pharmacy 3 days prior to the last dose. See attachment # 7</p> <p><i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Director of nursing will follow up with nursing staff to ensure orders are being filled and delivered.</p> <p><i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 9 blood sugar on 8/10/09 was 133 which did not require regular insulin</p>		

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F 309	<p>Continued From page 7</p> <p>congestive heart failure, chronic airway obstruction, hypertension, and anxiety.</p> <p>On 5/19/09, the facility's consultant pharmacist recommended on the Consultation Report to have the physician order a fasting lipid profile for the resident. On 5/20/09, the resident's physician approved of the recommendation, as documented on the Consultation Report.</p> <p>Nursing received the approved Consultation Report two months later on 7/14/09 and a lipid profile was performed on the resident on 7/16/09.</p> <p>An interview conducted on 8/19/09 at 11:45 AM, with a Licensed Practical Nurse (LPN), Employee #6 revealed that on 7/14/09, while reviewing a resident's chart, the LPN discovered a Pharmacy Consultation Report had been filed in the chart rather than being given to nursing. The LPN further indicated that she found ten other improperly filed reports, four of which needed immediate attention. Employee #6 explained that the normal procedure was for the physician to sign the reports and put them into the medical records box. Medical records would then give the reports to nursing. The LPN acknowledged that a new medical records assistant mistakenly filed the reports instead of giving them to nursing.</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on 6/26/09 with hemiplegia resulting from a cerebral vascular accident, aphasia and hypertension.</p> <p>Review of the physician's orders revealed an order for Tylenol 325 mg, 2 tabs by mouth every</p>	F 309	<p>Continued from page 7</p> <p>coverage. Clarification order to discontinue novolin regular insulin and change to humalog regular insulin was done on 8/10/09. See attachment F- 309, #8.</p> <p><i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i></p> <p>Facility will ensure that availability of novolin and humalog regular insulin are accessible in our drug emergency kit. Stock will be inventories every shift until par level is met.</p> <p><i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i></p> <p>Licensed nurses meeting was conducted on 9/9/09 by the DON to communicate this process effective immediately. Director of nursing will follow up with nursing staff to ensure orders are being filled and delivered.</p> <p><i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i></p> <p>Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p>	<p>Completion Date(s): 09/30/09</p>	

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F 309	<p>Continued From page 8 four hours as needed for pain.</p> <p>Documentation in the Nurse Notes on 7/11/09 at 1:35 PM revealed that the resident had "s/s (signs/symptoms) of pain left arm, gave Tylenol 650 mg for pain w/o (without) relief." The nurse then faxed the physician requesting something else for pain. The Medication Administration Record (MAR) revealed Resident #1 received an additional dose of Tylenol later that day.</p> <p>Nurses Notes dated 7/12/09 at 9:30 AM, disclosed that answers to the doctor's questions regarding the resident's pain were faxed back to the physician. At 9:35 AM, nearly twenty hours after the original request for something else for pain, Resident #1 received an order for Ultram 100 mg via G-tube every six hours as needed for pain. The MAR showed that since receiving the order for Ultram, the resident had been administered the stronger pain medication on an average of twice a day.</p> <p>The facility staff failed to ensure that the resident was medicated for pain in a timely manner.</p> <p>Resident #4</p> <p>Resident #4 was admitted to the facility on 7/14/09 with diagnoses of open wounds of the legs and knees, hypertension, debility, chronic pain and chronic obstructive pulmonary disease. He was oxygen dependent. He anticipated an eventual discharge back to his home.</p> <p>Due to his chronic pain and the additional pain of his open wounds, the resident was placed on a regimen of Morphine Sulfate ER 60 mg (a narcotic) every four hours. He received these</p>	F 309			

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PRINTED: 09/15/2009  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/21/2009</b>
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F 309	<p>Continued From page 9</p> <p>medications at 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, 10:00 PM and 2:00 AM. In addition, the resident was ordered Morphine Sulfate IR 15 mg by mouth every six hours as needed (pm) for break through pain. He routinely used this medication as well.</p> <p>The Nurses Progress Notes on 8/16/09 at 1:45 PM, revealed Resident # 4's routine pain medication (Morphine Sulfate ER 60 mg) was not received from the pharmacy.</p> <p>The Medication Administration Record (MAR) disclosed that the resident had not received his scheduled Morphine Sulfate ER 60 mg at 10:00 PM on 8/15/09, or at 2:00 AM, 6:00 AM, 2:00 PM or 6:00 PM on 8/16/09.</p> <p>An interview with Registered Nurse (RN), Employee #13, on 8/18/09 at 9:50 AM, revealed that when the RN came on shift, the night nurse reported to her that the pain medication was not available and that she had faxed the physician about the situation as well as notified the pharmacy. Employee #13 also stated when there was no response from the fax, she then notified the answering service. Meanwhile, Resident #4 was given the pain medication that had been ordered for break through pain every six hours. He received the lower dose medication at 8:15 AM and at 2:30 PM. At approximately 12:00 PM, the medical staff on call notified the facility leaving an order for an available pain medication (Roxanol). The medication, Roxanol, was ordered 20 mg orally every hour, after a loading dose of 20 mg, followed by additional 20 mg in 20 minutes.</p> <p>On 8/18/09 at 12:45 PM, an interview was</p>	F 309			

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F 309	<p>Continued From page 10</p> <p>conducted with Resident #4 about the non availability of his routine pain medication. He disclosed that he was in constant pain from the time that he did not receive his pain medication on 8/15/09, until the Roxanol was started at 12:15 PM on 8/16/09. The use of the as needed (prn) Morphine Sulfate did little to relieve his pain, and the use of the Roxanol minimized his pain but did not give him the relief afforded by the routine doses of Morphine Sulfate ER. The Morphine Sulfate ER was received at the facility at 10:00 PM on 8/16/09.</p> <p>The facility failed to ensure that the originally prescribed medication was available for the resident's use.</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on 9/26/08 with diagnoses including a right below the knee amputation, diabetes type II and anxiety.</p> <p>The resident's medical record revealed on 9/26/08, an order written for sliding scale coverage with Novolin Regular Insulin. Finger sticks were to be done each morning. On 8/02/09, a new order was written to do finger sticks for blood sugars every morning and at bedtime. New sliding scale coverage was ordered for a mild sliding scale coverage using "regular insulin."</p> <p>Nurses Notes dated 8/10/09 at 2:45 AM, documented "a finger stick of 213, with no insulin given because it was not available." Further documentation disclosed that the nurse notified the pharmacy to bring a supply of insulin. At that time the pharmacy requested clarification as to</p>	F 309			

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F 309	Continued From page 11 what type of regular insulin the physician wanted. The physician was then faxed a request for clarification of the order for regular insulin. Clarification of the insulin order was not received until 9:30 AM on 8/10/09 at which time the physician ordered Humalog insulin.  In a telephone interview on 8/21/09 with Registered Nurse (RN), Employee #10, who had made the entry, confirmed that Resident #9 did not receive insulin coverage for his blood sugar of 213 at bed time on 8/09/09 because none was available.  The Director of Nurses (DON), Employee #2, on 8/20/09, was asked about the order for the Regular Insulin not being clarified and the DON responded that staff knew the physician wanted to continue the use of Novolin Regular insulin as written in the previous sliding scale order of 9/26/08. However, when the physician clarified the order for the Regular Insulin on 8/10/09, he ordered Humalog Regular insulin not Novolin Regular insulin.  In a telephone interview with a pharmacist (#11) at the contracted pharmacy on 8/21/09, 8:35 AM, it was stated that the type of Regular insulin should be defined in the physician's order.  The facility failed to clarify the physician's order when it was written 8/02/09, failed to ensure that an adequate supply of necessary medication was available for the resident, and failed to ensure that the resident's evaluated blood sugar was treated.	F 309			
F 329 SS=E	483.25(l) UNNECESSARY DRUGS  Each resident's drug regimen must be free from	F 329	<u>Identifying Prefix Tag F - 392:</u> <u>UNNECESSARY DRUGS</u>		

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F 329	<p>Continued From page 12</p> <p>unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review, the facility failed to ensure that there was clinical justification, diagnoses or other indications to support the use of all medications ordered for 7 of 14 residents (Residents #1, #2, #3, #4, #8, #11, #12).</p> <p>Findings include:</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on</p>	F 329	<p>Continued from page 12</p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 2 Discharged on 8/16/09. Resident #9 Discharged on 8/25/09. Resident #1, #3, #4, #8, #11, #12. Physicians orders were reviewed on 8/27/09 by director of nursing and director of staff development as part of the monthly recap process to ensure that all medications ordered have corresponding diagnosis. <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> All facility resident orders were reviewed in this to ensure medications had a diagnosis. <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> On 9/21/09 an in-service was conducted be DON regarding the need of a diagnosis for each medication on admission, or medication changes. DON designee will audit records daily to ensure compliance. See attachment # 13 <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p>	<p>Completion Date(s): 09/30/09</p>

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F 329	<p>Continued From page 13</p> <p>2/24/09, with diagnoses including debility, adult failure to thrive, diabetes mellitus type II, right eye blindness, anemia, obesity, and diabetic neuropathy. The resident's medications included Demeclocycline HCL, Furosemide, Remeron, Tramadol HCL, Acetaminophen, Bisacodyl, Fleet Enema, Hydroxyzine HCL, Promethazine Suppository, Tegaderm and Oxygen.</p> <p>Resident #2's medication orders failed to reveal evidence there was clinical justification, diagnoses or other indications to support the use of the Demeclocycline HCL, Furosemide, Remeron, Promethazine Suppository, Tegaderm and Oxygen listed in the physician's orders.</p> <p>Resident #11</p> <p>Resident #11 was admitted to the facility on 3/3/09, with diagnoses including prostate cancer, secondary malignancy to the bone, chronic obstructive pulmonary disease, hypertension, generalized pain, anxiety, constipation and pressure ulcer. The resident's medication orders included Docusate Sodium, Lorazepam, Omeprazole, Senokot, Acetaminophen, Mylanta, Lorazepam, and Promethazine HCL.</p> <p>Review of Resident #11's medication orders failed to reveal evidence that there was clinical justification, diagnoses or other indications to support the use of the Docusate Sodium, Lorazepam, Omeprazole, Senokot and Mylanta listed in the physician's orders.</p> <p>On 8/19/09, review of the facility's policy number 4.3 dated 12/01/07, entitled "New Schedule III-V Controlled Substances and non-Controlled Medication," indicated for new orders, for either a</p>	F 329			

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F 329	<p>Continued From page 14</p> <p>new admission or for an existing residents, that the "Facility should ensure medication orders include drug name, strength, dose, route, frequency, indication for use and stop order parameters, if any."</p> <p>Resident #1</p> <p>Resident #1 was admitted to the facility on 6/26/09 with hemiplegia resulting from a cerebral vascular accident, aphasia and hypertension.</p> <p>Review of the recapped Physicians Orders for August 2009, disclosed that there were no diagnoses to support the use of the medications ordered.</p> <p>Resident #4</p> <p>Resident #4 was admitted to the facility on 7/14/09 with diagnoses of open wounds of the legs and knees, hypertension, debility, chronic pain and chronic obstructive pulmonary disease. He was oxygen dependent. He anticipated an eventual discharge back to his home.</p> <p>Review of the recapped Physicians Orders for August 2009, disclosed that there were no diagnoses to support the use of the medications.</p> <p>Resident #9</p> <p>Resident #9 was admitted to the facility on 9/26/08 with diagnoses including a right below the knee amputation, diabetes type II and anxiety.</p> <p>Review of the recapped Physicians Orders for August 2009, disclosed that there were no</p>	F 329			

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F 329	<p>Continued From page 15</p> <p>diagnoses to support the use of the medications.</p> <p>During an interview with the Director of Nurses (DON), Employee #2 on 8/20/09, the DON acknowledged that in the other buildings within the corporation that each medication order was accompanied by a diagnosis for its use.</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility on 1/8/09, with diagnoses including amputation below knee, unilateral, diabetes, and depression.</p> <p>The resident's medications included Paxil, Norvasc, Neurontin, Lisinopril, Lopressor, and Reglan. Review of Resident #3's medication orders failed to provide documented evidence of clinical justifications, diagnoses, or other indications to support the use of these medications.</p> <p>Resident #8</p> <p>Resident #8 was admitted to the facility on 12/29/08, with diagnoses including chronic obstructive pulmonary disease, coronary artery disease, hypertension, and anxiety.</p> <p>The resident's medications included Ativan, Norvasc, Diovan, Lasix, Synthroid, and Relafen. Review of Resident #8's medication orders failed to provide documented evidence of clinical justifications, diagnoses, or other indications to support the use of these medications.</p> <p>Resident #12</p> <p>Resident #12 was admitted to the facility on</p>	F 329			

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F 329	Continued From page 16 2/12/09, with diagnoses including Alzheimer's Disease, ischemic heart disease, and depressive disorder.  Medications included Aricept, Neurontin, Metoprolol, Zoloft, Zocor, Seroquel, Synthroid, and Imdur. Review of Resident #12's medications failed to provide documented evidence of clinical justifications, diagnoses, or other indications to support the use of these medications.	F 329			
F 371 SS=E	<b>483.35(i) SANITARY CONDITIONS</b>  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to ensure that food was prepared and served under sanitary conditions.  Findings include:  An inspection of the facility's kitchen during the survey period revealed the following:  Handwashing: On 8/18/09 at 9:00 AM, the Cook, Employee #5 was observed rinsing the wiping cloth in the food	F 371	<b>Identifying Prefix Tag F - 371: SANITARY CONDITIONS</b> <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Hand washing: The sanitizing solution was removed immediately removed from area and placed in proper location. Tray-delivery carts were immediately moved from hand washing area. Employee #5 and others observed have been counseled and in-service on the proper hand washing technique in accordance with the attached policy . <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Sanitizing solution will be kept in appropriate area. Dish clothes will be placed in appropriate solution between uses. Hand washing sink will remain easily accessible to dietary staff. The use of gloves and procedures for changing gloves will be enforced by food service manager. <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> RD will in-service staff regarding sanitation practices, easy access to hand		

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F 371	<p>Continued From page 17</p> <p>preparation sink, wiping the counter, and then using the same cloth to clean his hands. The wiping cloth was placed on the counter, rather than stored in a sanitizing solution between uses. The bucket containing the sanitizing solution was stored on a counter, where food was placed.</p> <p>On 8/18/09 at 9:15 AM, the Cook and the Dietary Supervisor, Employee #4, were interviewed. The Cook indicated that the wet cloth he used to clean the counters was also used to wipe off spills on tableware. The Dietary Supervisor agreed that kitchen staff should use a separate dry cloth for cleaning tableware, and that the bucket should be stored below the food counter.</p> <p>The kitchen's only hand sink was blocked by tray-delivery carts throughout the day, preventing easy access for handwashing.</p> <p>On 8/19/09 at 7:30 AM, Employee #5 was observed using bare hands while putting bread in the toaster. He then, put on gloves without first washing his hands. An unidentified facility employee was observed entering the kitchen through an outside back door and used the ice scoop to fill a pitcher with ice, without first washing her hands. On 8/20/09 at 2:30 PM, another unidentified cook was observed putting on gloves without first washing his hands. There was no evidence that the dietary department had a specific handwashing policy or a system in place to monitor handwashing.</p> <p>Food temperatures: On 8/19/09 at 12:00 PM, tray line food temperatures were checked. A container of chopped chicken was observed placed on top of a container of pureed chicken on the steam table.</p>	F 371	<p>Continued from page 17</p> <p>washing station, and hand washing procedure by 9/25/09. See attachment F 371, #1. Administrator or designee will spot check kitchen area daily and weekly to ensure compliance until lesser frequency is deemed appropriate. <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.</p> <p><i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Food temperatures: The proper placement of food containers was corrected immediately. <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> An in-service was given to all dietary staff on 9/25/09 by registered dietitian to emphasize proper placement of food containers in temperature regulation. See attachment F 371, #1 <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Food temperatures will be monitored daily by dietary manager and weekly by registered dietitian. Administrator or designee will randomly request a test tray to ensure temperatures are being met. <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with food</p>		

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F 371	Continued From page 18 The temperature of the chopped chicken was 104 degrees Fahrenheit (F). Employee #5 indicated that the containers were stacked because of a lack of space. The Dietary Supervisor acknowledged that the food containers were not supposed to be stacked on the steam table.  Washing of utensils: On 8/19/09 at 8:30 AM, Employee #5 was observed washing cooking utensils in the food preparation sink. The employee indicated that utensils were rinsed in that sink but later washed in the dishwashing machine.  Equipment: The temperature gauge on the dishwashing machine was broken.	F 371	Continued from page 18  temperatures or placement of containers will be brought to the attention for the Quality Assurance committee monthly and addressed immediately. <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Washing of utensils/Equipment: The gauge on the dish machine was immediately fixed. <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> The procedure for utensils and dishware use under emergency conditions will be followed. <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> An in-service was given to all dietary staff on 9/25/09 by registered dietitian. See attachment F 371, #1 <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee monthly and addressed immediately.		Completion Date(s): 09/30/09
F 425 SS=D	Cross-reference Tag 441 483.60(a),(b) PHARMACY SERVICES  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	<u>Identifying Prefix Tag F - 425:</u> <b>PHARMACY SERVICES</b> <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident # 4 Facility will ensure pharmacy provides adequate stock of routine pain medication. See attachment F- 309, # 7 <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i>		

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F 425	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide pharmaceutical services that dispensed medications in a timely manner for 1 of 14 residents (Resident #4).</p> <p>Findings include:</p> <p>Resident #4</p> <p>Resident #4 was admitted to the facility on 7/14/09 with diagnoses of open wounds of the legs and knees, hypertension, debility, chronic pain and chronic obstructive pulmonary disease. He was oxygen dependent. He anticipated an eventual discharge back to his home.</p> <p>The resident's routine pain medication of Morphine Sulfate ER 60 milligrams had been allowed to run out by facility staff. Documentation in the Nurses Notes for 8/16/09 at 1:45 PM disclosed that the pharmacy was "refaxed and phoned, that the medication had not been received." At 8:00 PM, the pharmacy was again notified about the non-availability of the pain medication. Facility staff were told that the medication had been given to the driver for delivery at 3:00 PM that day. The Morphine Sulfate finally arrived at the facility at 10:00 PM that night.</p> <p>In an interview with Resident #4, he disclosed that while he was given a substitute pain medication until the Morphine arrived, the substitute did not</p>	F 425	<p>Continued from page 19</p> <p>Refill orders of pain medication will be faxed to pharmacy 3 days prior to the last dose.</p> <p><i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Director of nursing will follow up with nursing staff to ensure orders are being filled and delivered. Administrator will ensure pharmacy services are being followed according to contracted agreement.</p> <p><i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee and addressed immediately.</p>	<p>Completion Date(s): 09/30/09</p>

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F 425	Continued From page 20 effectively diminish his pain.  When the delivery problem was researched by Employee #12, the Consultant Pharmacist, it was found that the delivery driver had not been informed of the importance of a rapid delivery of the medication to the facility and had chosen to put the facility at the end of his delivery route.  As a result of the untimely delivery, Resident #4 experienced unnecessary discomfort.	F 425			
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	<u>Identifying Prefix Tag F - 431:</u> <b>PHARMACY SERVICES</b> <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> All expired medications identified were destroyed on 8/19/09. See attachment # 11 <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Drawers for discontinued and expired drug storage were marked on 8/18/09. <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> In-service conducted by DON on 9/9/09 to licensed nurses regarding the need to destroy expired or discontinued drugs every shift as needed. Central Supply staff will check all house supply (OTC) drugs weekly to ensure compliance. See attachment # 5 <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance committee and addressed immediately.		Completion Date(s): 09/30/09

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F 431	<p>Continued From page 21</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure safe and proper storage of drugs and biologicals, and the removal of expired medications from house stock supplies.</p> <p>Findings include:</p> <p>On 8/17/09, an inspection of the medication room on the A Wing was made, with the following observations noted:</p> <ol style="list-style-type: none"> <li>1) Five bottles of house stock Rena Vite Tablets that had expired 2/09</li> <li>2) One bottle of house stock Tussin Cough Syrup that had expired 1/09</li> <li>3) Three bottles house stock Ondra Asprin 325mg that had expired 7/09</li> <li>4) One box house stock Ferrous Sulfate 160mg that had expired 6/09</li> <li>5) Two bottles house stock Bisacodyl 5mg that had expired March/2009</li> <li>6) Two bottles house stock Enteric Coated Asprin 325mg that had expired 4/2009</li> <li>7) One opened, used and undated bottle Calamine lotion that had been returned to stock</li> <li>8) One opened and dated 12/8/08, bottle of Enteric Coated Asprin returned to stock shelf</li> <li>9) Unmarked drawer with numerous residents' discontinued medications</li> </ol>	F 431			

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F 431	Continued From page 22 Immediately following the medication room observations, the Director of Nursing (DON), Employee # 2, was interviewed and acknowledged the medication room findings. The DON confirmed that the drawer with the discontinued medications, which were to be destroyed, should have been identified and labeled accordingly.	F 431			
F 441 SS=D	Observation of the medication cart for the B Hall on 8/18/09, disclosed an open vial of Humalog insulin. There was no date as to when the vial had been opened. <b>483.65(a) INFECTION CONTROL</b>  The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and policy review, the facility failed to ensure and monitor resident tuberculosis testing for the identification and prevention of infection of communicable disease, was not completed as required for 1 of 14 residents (Resident #2). The facility also failed to ensure that proper handwashing procedures were followed by	F 441	<b>Identifying Prefix Tag F- 441:</b> <b>INFECTON CONTROL</b> <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Resident #2 unable to correct discharged from the facility on 8/16/09. <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> On 9/22/09 all resident records were audited for compliance. All licenses nursing staff will be in-service regarding policy for resident tuberculosis testing. <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> The tuberculosis master control log will be tracked and maintained by the infection control nurse and monitored upon admit and monthly. Director of Nursing designee will audit the log every two weeks and monthly until a lesser frequency is deemed appropriate. <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality		

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F 441	<p>Continued From page 23 kitchen staff.</p> <p>Findings include:</p> <p>On 8/20/09, review of the facility's undated policy entitled, "Policy for Tuberculosis Testing of Resident's" stated: "It is the policy of this facility that all residents will be tested for tuberculosis upon admission and annually thereafter. Initial testing will be a two-step procedure, with the first dose given as soon as possible..."</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility on 2/24/09, with diagnoses including debility, adult failure to thrive, diabetes mellitus type II, right eye blindness, anemia, obesity, and diabetic neuropathy.</p> <p>Review of Resident #2's medical record revealed that admission tuberculosis (TB) skin testing was not started for approximately one week, after the resident was admitted. The first step, of the two step testing process, was initiated on 3/4/09.</p> <p>On 8/17/09, an interview with the A Wing charge nurse, Licensed Practical Nurse (LPN), Employee #6, indicated that new admission resident TB skin testing was to be started within 24 hours of the resident's admission to the facility. The LPN indicated that Resident #2 had been admitted in the late afternoon on 2/24/09, and in shift report it had been reported that the TB skin testing needed to be completed. The LPN further indicated that following Resident #2's admission that she had been off for a few days, and when she returned to duty the following week she had noticed that the TB testing had not been started.</p>	F 441	<p>Continued from page 23</p> <p>Assurance committee monthly and addressed immediately.</p>	<p><b>Completion Date(s): 09/30/09</b></p>	

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F 441	<p>Continued From page 24</p> <p>On 8/20/09, an interview with the facility's Director of Staff Development/Infection Control Coordinator, Registered Nurse, Employee #3, indicated that the infection coordinator was not responsible for resident testing. The Infection Control Coordinator further indicated that under the facility's infection control program, there currently were not any measures in place for the auditing or monitoring of the resident TB testing to ensure it was completed or that follow-up measures, when indicated were done.</p> <p>Handwashing:</p> <p>On 8/18/09 at 9:00 AM, the Cook, Employee #5 was observed rinsing the wiping cloth in the food preparation sink, wiping the counter, and then using the same cloth to clean his hands.</p> <p>On 8/18/09 at 9:15 AM, the Cook and the Dietary Supervisor, Employee #4, were interviewed. The Cook indicated that the wet cloth he was using to clean the counters was also used to wipe off spills on tableware. The Dietary Supervisor agreed that kitchen staff should use a separate dry cloth for cleaning tableware, and that the bucket should be stored below the food counter.</p> <p>The kitchen's only hand sink was blocked by tray-delivery carts throughout the day, preventing easy access for handwashing.</p> <p>On 8/19/09 at 7:30 AM, Employee #5 was observed using bare hands while putting bread in the toaster. He then put on gloves without first washing his hands. An unidentified facility employee was observed entering the kitchen</p>	F 441			

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F 441	Continued From page 25 through an outside back door and using the ice scoop to fill a pitcher with ice, without first washing her hands.  On 8/20/09 at 2:30 PM, another unidentified cook was observed putting on gloves without first washing his hands. There was no evidence that the dietary department had a specific handwashing policy or a system in place to monitor handwashing.	F 441			
F 443 SS=D	Cross-reference Tag 371 483.65(b)(2) PREVENTING SPREAD OF INFECTION  The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  This REQUIREMENT is not met as evidenced by: Based on personnel file review and document review, the facility failed to administer initial and annual tuberculosis skin tests within the recommended time frames for 1 of 10 files (Personnel File #1).  Findings include:  Personnel File #1 disclosed that the employee, a new hire, was administered a 1st step tuberculosis (TB) skin test on 5/26/09. The 2nd step was not administered until 7/13/09.  Review of the facility form entitled "Tuberculosis Individual Record" revealed the verbiage "the second skin test must be within 1-3 weeks if the	F 443	<b>Identifying Prefix Tag F - 443:</b> <b>PREVENTING SPREAD OF INFECTION</b> <i>Immediate corrective action(s) for those Residents affected by the deficient practice;</i> Personnel file #1 initial TD test given again 1 <sup>st</sup> step 8/27/09 second step 8/29/09. See attachment F443, #1. <i>Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken;</i> Employee TB record audit completed. See attachment F443, #2 <i>Facility measures and systemic changes to ensure the deficient practice does not recur;</i> Staff will be identified upon hire and monitoring will be done monthly by Staff Development Coordinator or designee, using the Employee Tuberculosis (PPD) Master Control Log. See attachment F443, #3 <i>Facility plan to monitor corrective actions &amp; sustain compliance; Integrate QA Process;</i> Concerns or trends with this process will be brought to the attention for the Quality Assurance Committee monthly and addressed immediately.	Completion Date(s): 09/30/09	

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F 443	Continued From page 26 initial test is negative."	F 443			

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